

December 7, 2012

NRC 2012-0117 10 CFR 50.73

Regional Administrator, Region III U. S. Nuclear Regulatory Commission 2443 Warrenville Road, Suite 210 Lisle, IL 60532-4352

Point Beach Nuclear Plant, Units 1 Dockets 50-266 Renewed License Nos. DPR-24

Licensee Event Report 266/2012-005-00 Potential Operation Prohibited by Technical Specifications

Enclosed is Licensee Event Report (LER) 266/2012-005-00 for Point Beach Nuclear Plant (PBNP), Unit 1. Pursuant to 10 CFR 50.73(a)(2)(i)(B), the event is reportable as a condition which was prohibited by Technical Specifications.

This submittal contains no new or revised regulatory commitments.

If you have questions or require additional information, please contact Mr. Mike Millen at 920/755-7845.

Very truly yours,

NextEra Energy Point Beach, LLC

for L. Meger

Larry Meyer ^{*l*} Site Vice President

Enclosure

cc: Administrator, Region III, USNRC Project Manager, Point Beach Nuclear Plant, USNRC Resident Inspector, Point Beach Nuclear Plant, USNRC PSCW

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(10-2010)							Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear						
LICENSEE EVENT REPORT (LER)								Regulatory Commission, Washington, DC 20555-0001, or by internet e- mail to infocollects.resourse@mrc.gov, and to the Desk Officer, Office of					
								burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e- mail to infocollects.resourse@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to the information collection.					
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LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

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NARRATIVE

Description of the Event

On October 8, 2012, Point Beach Nuclear Plant (PBNP) Unit 1 was operating in a steady state condition at 100% power with no plant evolutions in progress. At 2255, PBNP Operators declared Unit 1 Containment INOPERABLE due to a Service Water (SW) leak into Containment. Unit 1 entered Technical Specification Action Condition (TSAC) 3.6.1.A, with Required Action A.1 to Restore Containment to OPERABLE status with a Completion Time of one hour. On October 8, 2012, at 2355, Unit 1 entered TSAC 3.6.1.B, with Required Action B.1 to Be in MODE 3 with a Completion Time of six hours AND Required Action B.2 to Be in MODE 5 with a Completion Time of 36 hours.

NextEra Energy Point Beach, LLC (NextEra) personnel entered containment to determine the source of the SW leak, and found the leak to be on the common return piping for the B Train reactor cavity cooler. The leak was isolated by shutting the outside containment isolation valves. The leak was stopped, as verified by local observation inside containment. Containment was then declared OPERABLE, and the appropriate TSACs were exited.

Questions remain whether the Containment Leak Rate Testing Program (CLRT) inappropriately excluded these valves from Local Leakage Rate Testing (LLRT) requirements. If the valves that were closed should not have been credited for the containment isolation function, then Unit 1 should have been placed in MODE 3 by October 9, 2012 at 0555, and MODE 5 by October 10, 2012 at 1155. Instead Unit 1 remained at full power. The degraded pipe was repaired and returned to service on October 26, 2012 at 2119.

A supplement to the Licensee Event Report (LER) will follow once further review of the applicable regulatory guidance and industry practices is completed.

Pursuant to 10 CFR 50.73(a)(2)(i)(B), the event is being reported as a condition which was prohibited by Technical Specifications.

Cause of the Event

The Cause of the Event is still being investigated and will be updated in the supplement to this LER.

Analysis of the Event

NEI 94-01, which was endorsed by the NRC via Regulatory Guide 1.63, provides methods acceptable to the NRC staff for complying with Option B of 10 CFR 50 Appendix J. Section 6.0 General Requirements of NEI 94-01 states "An LLRT is not required for the following cases: Primary containment boundaries that do not constitute potential primary containment atmospheric pathways during and following a Design Basis Accident (DBA)..." This exception for not performing LLRT was assumed to be applicable to manual isolation valves of the SW system because the SW system is a closed system inside containment with no potential for a primary containment atmospheric pathway to outside containment. The operators followed the Technical Specifications as written, however the question raised is whether that allowance was made invalid when the piping became degraded. If so, then the isolation valves should have been tested or the LCO Actions should have been followed and the Unit shutdown.

Further review of this applicable regulatory guidance and industry practices will be completed and this LER will be supplemented as required.

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

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NARRATIVE

Analysis of Safety Significance

A qualitative risk assessment was performed assuming that a section of 2 inch SW piping inside the Unit 1 containment that is normally closed was open to containment atmosphere due to a through-wall leak. The SW pipe was isolated by the closure of the isolation valves outside containment. Closure of the valves does not adversely affect any key safety function.

This plant configuration does not increase the likelihood of a core damaging event. According to WCAP-16378-P, Westinghouse Owners Group Definition for Large Early Release Frequency (LERF), a general rule is that containment isolation failures with an equivalent diameter of greater than 2 inches are considered large. Because the size of the degradation in the pipe is much smaller than this, a release through this hole would not be considered large, and there would be no increase in LERF due to this issue.

Since the SW supply header remains pressurized above containment pressure during the period of an accident when fission products may be actively evolved from the core, leakage into the pressurized SW system is not considered to be a credible release path.

In addition to the immediate visual verification of leak-tightness by operators, SW return isolation valves in the same service on Unit 2 with comparable operating histories were leak tested during the Unit 2 refueling outage and demonstrated acceptably low leak rates. Consequently, the return valves on Unit 1 are also considered an insignificant potential release path.

Given the unlikely combination of a core damage event and a subsequent failure of either the pipe or valve, the release to the environment via the hole in the SW piping would not be classified as a large early release event. Therefore the issue is not significant.

Corrective Actions

The degraded piping was repaired and the closed system integrity was verified on October 26, 2012, restoring the closed system boundary.

Similar Events

None

Failed Components

None